CONTRA COSTA HEALTH

BHS Payment Reform Questions and Answers

#	Question	Response
1	Which CPT codes will be used for case management?	T1017 – Targeted Case Management – can be used for case management services. Available to all disciplines. See CPT Training presentation/PowerPoint under "Case Management Services."
2	Which CPT/HCPC codes will be used for collateral?	Collateral is no longer a distinct service code. Another CPT/HCPC code should be used for services when the client is not present. See CPT Training presentation/PowerPoint under "Collateral Services."
3	Can we charge for completing closing paperwork?	Billable time is based on direct service time only. Under payment reform (starting July 1, 2023) DHCS set rates that factored-in documentation time. Documentation time will be included as a separate field as part of service entry, but it will not be included in billable time. Time spent conjointly with the client in completing the transition tool form and making referrals are billable. An administrative closing is a non-billable service.
4	What is considered a non-billable service and which codes are allowed to be marked as non-billable?	There are different reasons for documenting non-billable services, such as lock-out situations (e.g., service at jail or IMD). The system is configured to allow any service (CPT/HCPC code) to be marked as non-billable. The decision is up to the clinician as to whether to mark the service as non-billable or keep it as billable. Other services such as money management, transportation, leaving voicemails will be available to document as "Other Service Provided" in ccLink and do not require CPT/HCPC codes.
5	Give examples of what to include in the direct service time, travel time, and documentation time.	If a case manager drove to a client's residence and it took 20 minutes to get to the location and 20 minutes to get back to the office (or origin point), provided a service with the client for 30 minutes, and took 15 minutes to write up the

#	Question	Response
		documentation and sign, then the travel would be 40 minutes, direct service time would be 30 minutes, and documentation time would be 15 minutes.
6	Why do we have to capture documentation time?	Documentation time can be substantial for services such as assessments and we want to measure this to get a true picture of service delivery. This may support advocacy with the State around how we bill and how rates are determined.
7	What is factored into productivity?	Productivity is measured in different ways depending on the end goal and data availability. One common method used by the county is to sum up all the time that factors into service delivery (direct service time, travel time, documentation time) and divide this total by the total amount of time worked by the staff person (excluding vacation, sick, holidays, etc.). Using this formula provides a metric that accounts for providers' time in relation to time that staff work (e.g., omitting vacation time).
8	Do we need to continue to indicate # of clients in group when entering these services or whether that's no longer necessary since the group rates are being handled in a new way.	Yes, you will still indicate # in group when documenting group services.
9	How much time should be documented if there are multiple facilitators and multiple clients in a group?	Each provider will document their own charges (total time) on their own encounter for each client in the group. For example, if there are 2 facilitators, 6 clients, and the group was 60 minutes, each provider would bill 60 minutes for each of the 6 clients; there will be a total of 12 encounters (6 for each provider). If a client leaves early, the provider should document the appropriate time the client was in the group.
10	Are we required to report clients who did not attend groups as No Shows?	We recommend contracted agencies collect No Shows and Cancellations in your records. For County BHS group appointments, No Shows and Cancellations will be tracked within the appointment system.
11	Will I need a new account for ccLink? All I have now is a login for the Provider Portal. How do I get access to ccLink? Will I get that access at the training?	Your same username and password for the Portal will work for ccLink, but where you access them from is different. The Portal is a web-based platform. ccLink Hyperspace will be accessed via the Citrix Gateway on the Contra Costa network.

#	Question	Response
		You'll test your access at training but you won't get access to ccLink Hyperspace for data entry until 7/1/2023.
12	Has a target date been established for when CBOs will be able to upload billing data into ccLink?	We do not have a timeline for the integration at this time, but we will be discussing this with leadership as we look to future prioritization of IT work. We need to estimate the work effort and also evaluate the different EHRs CBOs will be using post July 2023 as well as what will be needed from a specification standpoint.
13	Are we still limited to only 2 Service Strategies? Or can we enter more? Also it seems Service Strategy is a hard stop now, where it wasn't before. Is it required to choose at least ONE? (Service Information Form)	There is no limit to the number of service strategies allowed for each service.
14	Documentation Encounters: Clinicians and CSWs concerned that they won't be able to choose from 1 of the 2 codes that are listed there in the preference list. MDs have more codes to choose from, so do RNs but concern is not being able to see which codes they need. Is it possible to have a "Non-Bill" code? Or a logic that if we chose "non-billable" in Service Information Form, then we don't have to drop a charge in Charge Capture?	Services provided that correspond to a CPT or HCPCS code are documented under either the CPT/HCPCS tab or the CPT/HCPCS-Lockout tab. Non-billable services without a corresponding CPT/HCPCS code such money management, providing transportation, or leaving voicemails, etc. can be documented under the "Other Services Provided" tab.
15	99215 - Office Visit tops out at 45 minutes? And New patient tops out at 75 minutes? Which one do they choose?	Presented in Training: •99212 - Office or Other Outpatient Visit of an Established Patient, 19 Minutes or Less •99213 - Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes •99214 - Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes •99215 - Office or Other Outpatient Visit of an Established Patient, 40 Minutes or More
16	How do we do add-on codes? If we provided DBT CBT services within our service, should the EBP "yes" answer on the Service Information Form add a modifier in the background?	Clicking on the EBP option on the Service Information Form will capture the EBP information for the service. This information will not go out as a modifier in the claim file, but it will be saved in ccLink.

#	Question	Response
17	New vs established for E/M – the MediCal Manual definition is 'A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.' What is the definition of 'the same group practice'? Would this be our agency or the county system of care?	Network means county, CBO, and network providers. These are all considered part of the same system.
18	We used to have the Behavioral Evaluation code to bill CANS. Can/should we use 96127 Brief Emotional/Behavioral Assessment for working to obtain CANS information? If we cannot, should we just use the assessment codes (90791/H0031)? If we can use 96127 for CANS, since it is a CPT code this would only be able to be used by BBS registered staff, would an MHRS then use the H0031 code?	96127 is used by licensed staff and H0031 is used by unlicensed staff when they complete CANS because those domains contribute to the assessment.
19	When do we use H2021 Community-based wrap-around services? Do we use CalMHSA's definition, meaning it is to be used for wraparound program?	H2021 definition describes a condition and not a specific program so we believe it may be used if the condition is met.
20	When would we use 90885 Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes?	90885 was addressed in the training material.
21	When would we use code 99368 Medical Team Conference with Interdisciplinary Team of Health Care Professionals (Participation by Non-Physician. Patient and/or Family not present)? Could our FSP/ACT model team use this code for their morning meeting when discussing a high-risk client (clinician, peer partners, med provider, employment specialist are all present)?	We removed codes 99366 and 99368 because of all the restrictions these codes have and the potential to use incorrectly. Suggest using H0032 if the MD is not present.
22	If we provide psychoeducation to a caregiver around their child's mental health needs, this would have previously	Addressed in the training under Collateral.

#	Question	Response
	been billed as Collateral. Case management and psychosocial rehab do not exactly fit, which code would we use for this?	
23	I understand we need to continue to capture travel and documentation time, but we currently need to justify our travel time (i.e., drove from x to y in rush hour traffic). Do we need to continue doing this in our notes as of 7/1/23? Similar question for documentation time. We will now be tying back documentation time to a direct service to the client. Do we need to 'justify the documentation time' and indicate for example, that 10 mins was note writing and 45 minutes was for completing the assessment?	Travel time does not need to be justified. It should be entered in the service entry screen along with documentation time in ccLink.
24	Place of service code for Telehealth (02 and 10) – how do we select this if the service is not directly to the client (i.e., speaking with a caregiver over the phone or speaking on the phone with the client's social worker)?	Those are collateral services and telephone should be selected. 02 = telehealth provided in other than patient's home, and 10=telehealth provided when patient is in their home. This is the place of service field.
25	Who needs to do the interpretation to add supplemental code T1013? If the staff providing the service in the language of the participant (e.g., Spanish), would we add T1013? If another staff member from the program (i.e., Family partner) is interpreting, would we add T1013?	An official interpreter. It cannot be a family member or friend. If the therapist speaks the language of the client this does not count as an interpreter.
26	What modifier do we use for HCPC code provided via telehealth (audio/video) in outpatient setting? The modifier 'SC' is for telehealth audio only.	Modifiers 95 is used for audio/video; 93 is telephone - audio only -- for CPT codes. Modifier SC is only for the HCPCs codes and is audio-only. Place of service needs to be set up to 02 or 10. This is set up in the background in ccLink. Requesting clarification from DHCS on the correct modifier to use for video-based telehealth involving HCPCs codes.
27	Will we be using the 27 or 59 modifiers to 'override' lockouts? For example, right now we are allowed to bill for a therapy service that happened prior to intake to hospitalization/jail since it was prior to a	A modifier is not needed if the therapy occurred on the same day as admission.

#	Question	Response
	lockout. Would we now be required to use these modifiers to indicate this?	
28	How do we capture encounter with multiple services provided for the max billing? Within Med Management FU visit -- therapy is done, med management, crisis intervention (5150) and CPS report, JV220 for medication consent for foster kids is done, how should they accommodate all of these charges in Charge Capture? RN Example: Do Crisis Intervention and Med Injection (perhaps client has 5150 after med injection)	Only bundle like services for total time spent. If the nature of the service is different then you need to code the service with CPT/HCPC code that best fits what you have done with the client in a separate Documentation Encounter. Also, two providers can't write notes within the same encounter anymore.
29	Is there another possible Plan Development CPT code to add to charge capture for more administrative work? 364 Plan Development -- current code used for forms --- 99080 CPT exists for completing forms	Only bundle like services for total time spent. If the nature of the service is different then you need to code the service with CPT/HCPC code that best fits what you have done with the client in a separate Documentation Encounter. Also, two providers can't write notes within the same encounter anymore.
30	Is it possible to add the Telephone E&M Service codes into both sections (Assessment AND Plan Development header of charge capture?)	It is possible to put Telephone E&M service codes into both sections; however, for training purposes it was confusing to have codes duplicated in different sections. Specific codes can be saved as favorites so they are easy to find.
31	Is there a CPT code for Esketamine visits? Those can be up to 2 hours with observation and such. The current injection charge in Charge Capture only shows 15 minutes and is not one of the ones that direct them to change quantity.	This is self-administered and the protocol requires a 2-hour observation. We cannot use the injection code so I suggest we use a HCPC code H0034 - Medication Training and Support
32	Is there a CPT code for Spiralactone? Does not currently fit into the others listed in charge capture as it is not oral nor an injection.	We suggest using H0034 for this procedure. It is not a perfect match and we have asked DHCS for clarification.
33	Can you open the episodes and do admissions without going into an encounter? Child programs may do a bunch of admissions at the beginning of the school year.	Yes, go to Episodes of Care, create the episode and fill out the admission form

#	Question	Response
34	If we bill under the wrong provider, how do we correct that?	Error out the encounter and create a new encounter with the correct provider.
35	Is there a minute limit to sessions? Only 60? What if go over that?	CPT codes typically aren't limited to 60 minutes. Many of the codes are in 15-minute increments. If over the base 15, then we would use add-on codes to increase the service time. This will happen automatically in the system in the background.
36	What are the code numbers, like '90832' and how much time for each one? Where do they come up with these time amounts--any idea?	The time allocated for each CPT code is defined in the CPT codebook published by the American Medical Association (AMA). It is the standard used for healthcare billing throughout healthcare in the US. The billing manual reference for specialty mental health can be found here: https://www.dhcs.ca.gov/Documents/SMHS-Billing-Manual-v-1-4.pdf
37	Will there be different reimbursement rates for EMDR vs CBT vs DBT vs therapy as usual?	Reimbursement rates vary from county to county. Within each county rates vary depending on the provider type (e.g., physician, LPHA, Peer, etc.), but there are not different rates based on the modality.
38	How will Payment Reform impact the county financially?	We won't know the answer to this until there is some history of revenue generated through the claim cycle. DHCS has based its rates based on a host of factors at the county level (e.g., cost of living, labor costs, cost reports, etc.) and has modeled rates such that counties would be reimbursed at a comparable or higher rate than historical averages. We are not expecting a significant fiscal impact on the county or CBOs, but will only know after July 1 and the claiming system is effective. This will be closely monitored.
39	How do we track documentation?	Documentation time is a specific field in ccLink as part of charge capture.
40	Just for clarification, the 60% productivity expectation is direct billable hours or in total now?	The 60% productivity metric is the sum total of direct service time, travel time, and documentation time. Effectively it is the same metric as what is currently in use.
41	Do the codes account for travel time for a mobile program that sees patients at home ?	Travel time is not included when selecting the appropriate CPT code. DHCS has already built in travel time as part of the rate setting.

#	Question	Response
42	If we say that there is interactive complexity, do we need to justify that in the note?	Yes, if Interactive Complexity is selected it should be documented and substantiated in the note.
43	If someone is a Spanish speaker helping a Spanish speaking client, is that considered interactive complexity?	A Spanish speaking clinician working with a Spanish speaking client would not use interactive complexity. Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure, not language issues per se. There are several slides in the training that provide more details.
44	Some of the CPT and HCPCS codes have long names, can we abbreviate or shorten it?	Shortening the label is OK as long as users understand. Service entry into ccLink will show both the code and a short description. We recommend you put in enough of a code label into your EHR so that it is meaningful to users.
45	Can we make the codes specific to each discipline?	The codes available to providers in ccLink will be limited to their scope of practice.
46	Under the Assessment Codes there are different codes e.g., Telephone Evaluation (99441) when to use those as opposed to Assessment (90792)?	There is some flexibility in CPT and HCPCS codes. To simplify the code selection process some codes (including 99441) are no longer included as options for MDs because the service activity can be documented using other codes.
47	Are there still limits to how much time can be billed for an Assessment? For example, pre 7/1 was limited to 3 hrs max for an Assessment. So if other activities were done beyond the 3 hours, clinicians are writing additional progress notes to bill/account for the time above 3 hrs	With CalAIM documentation reform assessments can occur over time and not necessarily as a one-time event. The amount of time spent with a client is based on client needs and appropriateness of the level of service. There is not a limit of 3 hours for the Assessment codes.